INVESTIGATE PROSECUTE PROTECT
BMFEA
Bureau of Medi-Cal Fraud & Elder Abuse
State of California Department of Justice

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Memorandum

To: Jeffrey Maggard, Administrator
Evergreen Healthcare Centers of Vallejo- Springs Road

From: Operation Guardians

Date: January 28, 2010

Subject: **Operation Guardians Inspection**

On January 19, 2010, the Operation Guardians team conducted a surprise inspection of Evergreen Healthcare Center of Vallejo- Springs Road. The following summary is based upon the team's observations, plus documents and information provided by the facility.

Nursing Medical Chart Review:

1. The medical chart review of resident 10-01-01 showed the resident was admitted to the facility on May 31, 2006 with a cerebral vascular accident, multiple sclerosis, dysphagia with gastrostomy feeding tube, and urinary retention requiring a Foley catheter. Documentation indicated he was unable to turn or reposition himself in bed or make his needs known.

   At approximately 0800 hours, the resident was observed with the head of the bed elevated between 50 to 60 degrees and he was positioned slightly onto his left side. At 1100 hours, the team observed the resident in the same position. The team nurses asked for the resident to be turned so the resident's back, coccyx, and buttocks could be examined. The licensed nurse and an assistant turned the resident to his right side. He was observed to be lying on wrinkled linen and had marks on his back indicating the pressure. The resident's diaper was removed and the skin assessment showed bilateral stage II pressure ulcers to the buttocks. This was brought to the attention of the licensed nurse. He also was lying in a feces soiled diaper with old, dry stool. The team nurses returned to check

on the resident at 1200 hours and found the resident had just been cleaned and changed at that time, an hour after the soiled diaper was discovered. This is unacceptable nursing care and considered resident neglect.

Review of the medical record showed the resident had a history of frequent pressure ulcers on his buttocks. The Care Plan indicated the pressure ulcers were a problem but the plan and interventions were not appropriate for the resident's care and not being followed by the nursing staff. There was no documentation in the nurses' notes, assessments, or facility skin logs of the resident's current pressure ulcers. This was brought to the attention of the Director of Nurses.

The bedside suction machine cannister had approximately two inches of a milky white liquid in the cannister. The cannister was not dated and it was unclear the last time the cannister had been changed. The licensed nurse reported it was not necessary to date the cannister because it was changed when it became full, which was every few days because the resident required suctioning three times a day.

Review of the Treatment Authorization Record (TAR) for the resident indicated the resident was to be suctioned three times a day and as needed. According to the January 2010 TAR, he was not being suctioned as ordered by the physician. Initials were missing six out of eighteen days on the 0900 and 1700 hour time slots. Weekly skin checks and urine assessments were also not being performed by the licensed nurses.

The team observed a sign above the resident's bed indicating he was to have a Dynasplint applied daily to his right hand. By 1200 hours, the resident did not have the splint on as ordered and continued to only have hand rolls to both hands. The team questioned the licensed nurse and she instructed the team to talk with the Physical Therapy department as they were responsible for placing the splint. The Occupational Therapist reported they were no longer responsible for placing the splint as he had been discharged from the Therapy department and was now the responsibility of the Restorative Nurses' Assistants (RNA). The medical chart showed a physician order was written on November 11, 2008 stating the RNA program was to take over the daily placement and removal of the Dynasplint. Review of the RNA book showed that 6 out of the 18 days for January 2010, the splint had not been applied as the time slots were empty without initials. It was concerning to the team the facility staff were not aware of who was responsible for the treatment of the resident and it appeared there was no oversight for the RNA program.

2. Review of the Treatment Records showed 35 residents out of the census of 50 were not receiving the ordered skin checks, pressure ulcer treatments, and other therapies as ordered by the physicians. This lack of nursing interventions compromises the residents care causing undue harm and neglect.

Facility Environmental Observations:

1. Upon the initial walk-through of the facility, it was noted the facility's most recent

Licensing and Certification survey for 2009 was not posted for the public to view. The administrator informed the team leader a sign was on the entry table directing the public to nursing station I. No sign was observed on the table and the administrator could not locate the sign. He indicated the sign must have been removed.

2. The building was observed filthy and required deep cleaning in all areas of resident and departmental areas. The observed unsanitary areas of the facility will be addressed throughout this memorandum.

3. The Central Supply room door was not latched and therefore it was unlocked. The room contained over-the-counter medications, sterile supplies and other medical supplies. The floor of the room was filthy with debris and dirt thus requiring deep cleaning.

4. The Utility Room located across from room 27 was observed unlocked. Upon entering the room, the team noted a filthy ceiling exhaust fan cover. The sides of the room were labeled clean and dirty however it was difficult to determine which side was dirty. The dirty side had a box of examination gloves, wipes and tissues on top of the counter. The clean side had filthy cabinets indicating something had been spilled down the front of the cabinets. The sink's drains were corroded and needed to be replaced. The cabinets under the sink were not locked and contained chemicals. The cabinets above the sink were also unlocked and contained disposable razors. These are safety issues for the facility residents.

5. The Nursing Supply storage room located across from room 25 was observed with a filthy bathtub. The tile surrounding the tub was either physically removed or there was dry rot causing the tiles to fall off the wall. It was unclear if the room was being utilized for resident use. The room also contained cardboard boxes of supplies being stored on the floor. A cart with a pink colored covering was noted to be storing water pitchers. The team leader moved the cart away from the wall and on the floor where the cart was stored were numerous emesis basins. The floor in this room was filthy and required immediate deep cleaning.

6. The medication refrigerator at Nursing Station 1 had an open and undated vial of Aplisol used to test for Tuberculosis.

7. Room 28 was observed with a sticky, grimy floor. The bedside stand for the A bed was also sticky as if something had been previously spilled on it. Both of the male resident's urinals were on the floor. The urinals had no name or room number to identify whom it belonged to. This is an infection control issue. The black mats on the floor next to the resident's beds were filthy. The resident's call lights were on the floor at the head of the beds. This could be considered resident neglect. This resident room was in need of deep cleaning.

8. Many of the bed cranks were sticking out from the end of the beds throughout the facility. This is a safety issue for the facility residents.

9. The supply closet by room 20 had a filthy door, flooring and shelving. There was a tan colored cart with left-over food dated from 1/18/10. The shelf contained a clear plastic bin containing nourishments. This filthy supply closet should not be utilized for resident foods.

10. The oxygen supply room located by room 11 was observed with debris on the floor.

11. The linen closet by room 7 was observed with a filthy floor and debris on the blankets stored on the bottom shelf. This is an infection control issue.

12. The building was very cold while the team toured at 8:00 AM. Several resident rooms were observed with sliding doors and windows open. The weather was stormy and cold on the day of the inspection. The temperature of the building eventually increased after the management staff arrived to the facility.

13. Room 16 bathroom was observed with a light bulb not functioning, cob webs in the ceiling sprinkler head and missing baseboards.

14. The brown colored upholstered chairs in the dining room were filthy and required deep cleaning. Many Geri-chairs and wheelchairs were observed with torn vinyl. This can cause skin tears to the fragile elder skin.

15. The kitchen was observed with a filthy floor and standing water on the floor located by an exit. One of the exits utilized hanging plastic strips in place of a screen door. There were large gaps in the plastic allowing flying insects and vermin to enter the kitchen. The outside refrigerated unit was observed with a door that did not latch. The floor in the walk-in was moist and the cardboard boxes containing the vegetables were also damp. The door issue was presented to the dietary supervisor. The team leader recommend for the kitchen staff to keep the lock in the latch to keep the door securely closed. A kitchen employee was observed cutting meat on a electrical meat slicer by the exit door with the hanging plastic strips. The team leader recommended to the supervisor for the meat to be cut somewhere more sanitary.

16. The shower room located across the hall from the Activity Director's office had a dirty curtain covering the door. There was mold on the tiles where the faucet protruded from the shower wall. A fifty cent size hole was also observed in the tile about a foot above the floor on the same wall. The ceiling ventilation cover was filthy and had peeling paint around the metal cover.

Administrative Observations:

1. The CPR/Emergency cart's check list had not been signed off by a licensed nurse for the month of January 2010. This indicated a nurse had not checked the cart making sure the appropriate supplies were available and in working condition in case of an emergency. This could be a severe health and safety issue for the facility residents.

2. Many resident's call lights were observed on the floor or out of reach for the resident. This can be considered neglect and/or abuse. Some of the residents observed without call lights were in rooms 23 B and 24 C. The call light was tied to the bed rail behind the resident in bed 4 A.

3. The team observed the Hoyer lift and a large standing scale stored in the hallway. The standing scale was very unstable in it's position and thought to be a safety hazard if a resident grabbed onto it for support during ambulation.

4. Several residents residing in the facility did not appear to need the level of care required for 24-hour skilled nursing care.

5. The facility's Abuse Prevention Program Policies and Procedures did not follow **state** law. It must immediately be corrected to accurately state the code definition under Welfare and Institutions Code 15630 (b) (1) **any mandated reporter (not only the administrator or a department head)...reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone immediately (A) to the local ombudsman or the local law enforcement agency.** The current facility policy does not follow state law as the document did not include reporting to the Ombudsman or local law enforcement when suspected or witnessed abuse occurred. The team leader interviewed a CNA and LVN each working a different unit. They reported they had been instructed to complete a facility's investigation document and submit it to their supervisor. They were not aware of their responsibility to complete the SOC 341 form.

Staffing:

Based on the records provided by the facility, staffing levels were below the minimum required 3.2 hours per resident day (hprd) on three of the six days randomly reviewed. The average HPPD was 3.0 hours.

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some point next year, the contents of this letter may be

released to the public.

We encourage your comments so they can be part of the public record as well. Please send any comments to Cathy Long NEII at 1425 River Park Drive, Sacramento, California 95815. She may also be reached by telephone at (916) 274-2913.